

STATE OF ILLINOIS

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Facility Name & ID Number PROVENA COR MARIAE CENTER# 0041046 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>22,995</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>89</u>	Sheltered Care (SC)	<u>89</u>	<u>32,485</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>152</u>	TOTALS	<u>152</u>	<u>55,480</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF	<u>4,049</u>	<u>8,691</u>	<u>5,585</u>	<u>18,325</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>0</u>	<u>4,404</u>	<u>0</u>	<u>4,404</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>29,681</u>	<u>0</u>	<u>29,681</u>	12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>4,049</u>	<u>42,776</u>	<u>5,585</u>	<u>52,410</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.47%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/5/1995

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/1/1995 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 41 and days of care provided 5,585Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

PROVENA COR MARIAE CENTER

0041046

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	354,927	5,611	63,685	424,223		424,223		424,223			1
2	Food Purchase		247,098		247,098		247,098	1,493	248,591			2
3	Housekeeping	130,204	42,870	407	173,481		173,481		173,481			3
4	Laundry	54,771	1,828	9,119	65,718		65,718		65,718			4
5	Heat and Other Utilities			244,765	244,765		244,765	3,809	248,574			5
6	Maintenance	105,462	17,118	102,426	225,006		225,006	825	225,831			6
7	Other (specify):*	20,413	2,838		23,251		23,251		23,251			7
8	TOTAL General Services	665,777	317,363	420,402	1,403,542		1,403,542	6,127	1,409,669			8
	B. Health Care and Programs											
9	Medical Director			14,200	14,200		14,200		14,200			9
10	Nursing and Medical Records	1,671,789	82,552	46,160	1,800,501		1,800,501	(21)	1,800,480			10
10a	Therapy		4,154	261,291	265,445		265,445		265,445			10a
11	Activities	134,412	1,841	374	136,627		136,627		136,627			11
12	Social Services	56,626	119	703	57,448		57,448		57,448			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,862,827	88,666	322,728	2,274,221		2,274,221	(21)	2,274,200			16
	C. General Administration											
17	Administrative	253,282	3,207	705,501	961,990		961,990	(333,323)	628,667			17
18	Directors Fees											18
19	Professional Services			108,169	108,169		108,169	33,729	141,898			19
20	Dues, Fees, Subscriptions & Promotions			72,345	72,345		72,345	(59,401)	12,944			20
21	Clerical & General Office Expenses		50,124	29,142	79,266		79,266	(144,864)	(65,598)			21
22	Employee Benefits & Payroll Taxes			566,431	566,431		566,431	49,167	615,598			22
23	Inservice Training & Education			15,700	15,700		15,700	1,972	17,672			23
24	Travel and Seminar			2,796	2,796		2,796	5,310	8,106			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			31,584	31,584		31,584		31,584			26
27	Other (specify):*			289,633	289,633		289,633	(289,633)				27
28	TOTAL General Administration	253,282	53,331	1,821,301	2,127,914		2,127,914	(737,043)	1,390,871			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,781,886	459,360	2,564,431	5,805,677		5,805,677	(730,937)	5,074,740			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

PROVENA COR MARIAE CENTER

#0041046

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			279,931	279,931		279,931	(98,985)	180,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							191,697	191,697			32
33	Real Estate Taxes			1,765	1,765		1,765		1,765			33
34	Rent-Facility & Grounds							12,983	12,983			34
35	Rent-Equipment & Vehicles			28,930	28,930		28,930	290	29,220			35
36	Other (specify):*											36
37	TOTAL Ownership			310,626	310,626		310,626	105,985	416,611			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			675,526	675,526		675,526		675,526			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,500	34,500		34,500		34,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			710,026	710,026		710,026		710,026			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,781,886	459,360	3,585,083	6,826,329		6,826,329	(624,952)	6,201,377			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(102,820)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(106,528)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(289,633)	27		24
25	Fund Raising, Advertising and Promotional	(63,649)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (562,680)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(11,340)	Var	34
35	Other- Attach Schedule	(50,932)	Var	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (62,272)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (624,952)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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PROVENA COR MARIAE CENTER

Page 5A

ID# 0041046
Report Period Beginning: 1/1/2002
Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Marketing Benefits	\$ (2,717)	22	1
2	Non-Allowable Marketing Benefits	2,209	22	2
3	Non-Allowable Marketing Benefits	170	22	3
4	Non-Allowable Marketing Benefits	628	22	4
5	Non-Allowable Marketing Related Expense	(5,815)	17	5
6	Non-Allowable Marketing Related Salary	(38,570)	21	6
7	Non-Allowable Marketing Benefits	0	22	7
8	Non-Allowable Marketing Related Expense	(123)	21	8
9	Non-Allowable Marketing Related Expense	(6,407)	21	9
10	Non-Allowable Marketing Related Expense	(307)	17	10
11	Non-Allowable Travel Expense	0	24	11
12	0	0		12
13	0	0		13
14	0	0		14
15	0	0		15
16	0	0		16
17	0	0		17
18	0	0		18
19	0	0		19
20	0	0		20
21	0	0		21
22	0	0		22
23	0	0		23
24	0	0		24
25	0	0		25
26	0	0		26
27	0	0		27
28	0	0		28
29	0	0		29
30	0	0		30
31	0	0		31
32	0	0		32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(50,932)		49

Summary A

12/31/2002

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(102,820)	0	3,835	0	0	0	0	0	0	0	0	(98,985)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	191,697	0	0	0	0	0	0	0	0	191,697	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	12,983	0	0	0	0	0	0	0	0	12,983	34
35	Rent-Equipment & Vehicles	0	0	290	0	0	0	0	0	0	0	0	290	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(102,820)	0	208,805	0	0	0	0	0	0	0	0	105,985	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(613,612)	(225,455)	214,115	0	0	0	0	0	0	0	0	(624,952)	45

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
0		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 FOOD PURCHASE	\$	PROVENA SENIOR SERVICES	100.00%	\$ 1,493	\$ 1,493 1
2	V	3 HOUSEKEEPING-SUPPLIES		PROVENA SENIOR SERVICES	100.00%	0	0 2
3	V	5 HEAT & OTHER UTILITIES		PROVENA SENIOR SERVICES	100.00%	3,809	3,809 3
4	V	6 MAINTENANCE-OTHER		PROVENA SENIOR SERVICES	100.00%	825	825 4
5	V	10 NSG & MED REC-SAL-LPN		PROVENA SENIOR SERVICES	100.00%	(21)	(21) 5
6	V	17 ADMIN-SALARY-OTHER ADMIN		PROVENA SENIOR SERVICES	100.00%	183,730	183,730 6
7	V	17 ADMIN-OTHER	555,378	PROVENA SENIOR SERVICES	100.00%	44,497	(510,881) 7
8	V	19 PROFESSIONAL SERVICES		PROVENA SENIOR SERVICES	100.00%	33,729	33,729 8
9	V	20 DUES, FEES, SUBS & PROMOTIONS		PROVENA SENIOR SERVICES	100.00%	4,248	4,248 9
10	V	21 CLERICAL/GEN-SUPPLIES		PROVENA SENIOR SERVICES	100.00%	5,070	5,070 10
11	V	21 CLERICAL/GEN-OTHER		PROVENA SENIOR SERVICES	100.00%	1,694	1,694 11
12	V	22 EMP BENEFITS & PAYROLL TAXES		PROVENA SENIOR SERVICES	100.00%	48,877	48,877 12
13	V	23 INSERVICE TRAINING & EDUCATION		PROVENA SENIOR SERVICES	100.00%	1,972	1,972 13
14	Total		\$ 555,378			\$ 329,923	\$ * (225,455) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	24 TRAVEL & SEMINAR	\$	PROVENA SENIOR SERVICES	100.00%	\$ 5,310	\$ 5,310	15
16	V	30 DEPRECIATION		PROVENA SENIOR SERVICES	100.00%	3,835	3,835	16
17	V	32 INTEREST		PROVENA SENIOR SERVICES	100.00%	191,697	191,697	17
18	V	34 RENT-FACILITY & GROUNDS		PROVENA SENIOR SERVICES	100.00%	12,983	12,983	18
19	V	35 RENT-EQUIPMENT & VEHICLES		PROVENA SENIOR SERVICES	100.00%	290	290	19
20	V	17 ADMIN-OTHER	131,974	PROVENA HEALTH SERVICES	100.00%	131,974		20
21	V	19 PROFESSIONAL SERVICES	52,404	PROVENA HEALTH SERVICES	100.00%	52,404		21
22	V	39 ANCILLARY SERVICE CENTERS-OTH	675,526	PROVENA SEENIOR SERVICES PHARMACY	100.00%	675,526		22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 859,904			\$ 1,074,019	\$ * 214,115	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PROVENA COR MARIAE CENTER** # **0041046** Report Period Beginning: **1/1/2002** Ending: **12/31/2002**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PROVENA SENIOR SERVICES
 Street Address 200 E COURT STREET, SUITE 200
 City / State / Zip Code KANKAKEE, IL 60901
 Phone Number (815)928-6851
 Fax Number (847)928-6160

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD PURCHASE	MGT FEE INCOME	5602865	16	\$ 15,066	\$ 555,378	\$ 1,493	1
2	3	HOUSEKEEPING-SUPPLIES	MGT FEE INCOME	5602865	16	3	555,378	0	2
3	5	HEAT & OTHER UTILITIES	MGT FEE INCOME	5602865	16	38,430	555,378	3,809	3
4	6	MAINTENANCE-OTHER	MGT FEE INCOME	5602865	16	8,321	555,378	825	4
5	10	NSG & MED REC-SAL-LPN	MGT FEE INCOME	5602865	16	(213)	555,378	(21)	5
6	17	ADMIN-SALARY-OTHER ADM	MGT FEE INCOME	5602865	16	1,853,538	1,853,538	183,731	6
7	17	ADMIN-OTHER	MGT FEE INCOME	5602865	16	448,903	555,378	44,497	7
8	19	PROFESSIONAL SERVICES	MGT FEE INCOME	5602865	16	340,270	555,378	33,729	8
9	20	DUES, FEES, SUBS & PROMOT	MGT FEE INCOME	5602865	16	42,856	555,378	4,248	9
10	21	CLERICAL/GEN-SUPPLIES	MGT FEE INCOME	5602865	16	51,149	555,378	5,070	10
11	21	CLERICAL/GEN-OTHER	MGT FEE INCOME	5602865	16	17,089	555,378	1,694	11
12	22	EMP BENEFITS & PAYROLL T	MGT FEE INCOME	5602865	16	493,092	555,378	48,877	12
13	23	INSERVICE TRAINING & EDU	MGT FEE INCOME	5602865	16	19,896	555,378	1,972	13
14	24	TRAVEL & SEMINAR	MGT FEE INCOME	5602865	16	53,573	555,378	5,310	14
15	30	DEPRECIATION	MGT FEE INCOME	5602865	16	38,693	555,378	3,835	15
16	32	INTEREST	MGT FEE INCOME	5602865	16	1,933,910	555,378	191,697	16
17	34	RENT-FACILITY & GROUNDS	MGT FEE INCOME	5602865	16	130,976	555,378	12,983	17
18	35	RENT-EQUIPMENT & VEHICL	MGT FEE INCOME	5602865	16	2,925	555,378	290	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,488,477	\$ 1,853,325		\$ 544,039	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PROVENA HEALTH SERVICES
 Street Address 9223 WEST ST. FRANCIS ROAD
 City / State / Zip Code FRANKFURT, IL 60423
 Phone Number (815)469-4888
 Fax Number (815)469-4864

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMIN-OTHER	DIRECT ALLOCATION			\$	\$		\$ 131,974.00	1
2	19 FESSIONAL SERVICES	DIRECT ALLOCATION						52,404.00	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 184,378	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization PROVENA SEENIOR SERVICES PHARMACY
 Street Address 1475 HARVARD DRIVE
 City / State / Zip Code KANKAKEE, IL 60901
 Phone Number (815)928-6141
 Fax Number (815)946-3238

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Y SERVICE CENTERS-OTHER	DIRECT ALLOCATION		\$	\$		\$ 675,526	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 675,526	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	PROVENA SENIOR SERVICES											191,697	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ 191,697	14
15	TOTALS (line 9+line14)						\$					\$ 191,697	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046** Report Period Beginning: **1/1/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 942	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 942	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 823	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 1,765	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	10	
	2000	942	11
	2001		12
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA COR MARIAE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT Karl Baker

TELEPHONE (314) 231-5544 FAX #: (317)581-9513

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A.

Square Feet:

110,404

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

5

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		1995	\$ 670,894	1
2					2
3	TOTALS			\$ 670,894	3

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995	1964	\$ 725,291	\$	25	\$ 24,176	\$ 24,176	\$	4
5				1997	1,819,208		25	45,484	45,484		5
6											6
7											7
8											8
		Improvement Type**									
9		VARIOUS		1995	130,484		20	10,107	10,107	51,363	9
10		VARIOUS		1996	326,652		20	7,748	7,748	42,613	10
11		VARIOUS		1997	119,249		20			119,249	11
12		VARIOUS		1998	136,102		20	6,827	6,827	30,723	12
13		FINANCIAL STMT DEPREC				179,106	20		(179,106)		13
14		FIRE ALARM CONTROL PANEL		1999	2,029		20	406	406	1,420	14
15		ROOFING REPAIR		1999	415		20	83	83	291	15
16		ROOFING REPAIR		1999	6,429		20	1,286	1,286	4,501	16
17		CLEAR PLATE (4)		1999	446		20	45	45	157	17
18		BLDG IMPROVEMENTS-LOWE		1999	454		20	91	91	318	18
19		BLDG IMPROVEMENTS-TOM W MAR		1999	493		20	99	99	346	19
20		DOORS, FRAMES, HARDWARE		1999	681		20	136	136	477	20
21		OUTSIDE LIGHTS Y2K		1999	443		20	89	89	311	21
22		NONCARE PORTION OF LIMP		1999	(2,523)		20	(495)	(495)	(1,732)	22
23		BOILER CONTROL REPAIRS		2000	2,182		20	136	136	790	23
24		COMPLETED SIGNED REPAIRS		2000	12,500		20	2,500	2,500	6,250	24
25		SMARTUP REPLACEMENT VOICE/MAIL		2000	503		20	101	101	252	25
26		WALL FLASHING		2000	856		20	171	171	428	26
27		CRM COMMON AREA ASSESSMENT		2000	3,747		20	749	749	1,873	27
28		BALLAST AND 6 LAMPS		2000	641		20	128	128	320	28
29		RGB MAJOR BUILDING CONSULTING		2000	11,212		20	1,121	1,121	2,803	29
30		RGB ARCHITECTURAL SERVICES		2000	855		20	171	171	428	30
31		RGB ARCHITECTURAL SERVICES		2000	1,325		20	265	265	663	31
32		CEILING TILE		2000	547		20	55	55	137	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12E, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981

**Improvement type must be detailed in order for the cost report to be considered complete.

1/1/2002 Ending: 12/31/2002

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,300,221	\$ 179,106		\$ 101,479	\$ (77,627)	\$ 263,981	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 796,448	\$ 96,575	\$ 69,529	\$ (27,046)	10	\$ 411,060	71
72	Current Year Purchases	23,262		2,794	2,794	10	1,775	72
73	Fully Depreciated Assets	6,880					6,880	73
74								74
75	TOTALS	\$ 826,590	\$ 96,575	\$ 72,323	\$ (24,252)		\$ 419,715	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1991 CHEVY PICKUP	1995	\$ 14,000	\$ 4,250	\$ 4,250		5	\$ 14,000	76
77	Plant Engineering	2000 FORD ELDORADO	2000	42,500	4,250	4,250		5	10,625	77
78		NONCARE PORTION	2001	(15,062)		(941)	(941)	5	(8,001)	78
79										79
80	TOTALS			\$ 41,438	\$ 4,250	\$ 3,309	\$ (941)		\$ 16,624	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,839,143	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 279,931	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 177,111	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (102,820)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 700,320	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation-Pr				12,983			5
6	NonCare Por				(3,874)			6
7	TOTAL				\$ 9,109			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 29,220 Description: Nursing \$21526, Dietary \$80, Activity \$3607, Plant \$449, Administration \$3268, Home Office Allocation \$290
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____
13. /2004 \$ _____
14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	10a, 3	hrs	\$	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		755	18,339	0	755	18,339	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		3,046	146,210	4,154	3,046	150,364	4
5	Physician Care		visits				0			5
6	Dental Care		visits				0			6
7	Work Related Program		hrs				0			7
8	Habilitation		hrs				0			8
9	Pharmacy		# of prescrpts				675,526		675,526	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs				0			10
11	Academic Education		hrs				0			11
12	Exceptional Care Program						0			12
13	Other (specify):									13
14	TOTAL			\$	6,253	\$ 261,291	\$ 679,680	6,253	\$ 940,971	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,805,729	\$	1
2	Cash-Patient Deposits	81,389		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,148,529		3
4	Supply Inventory (priced at)	433,891		4
5	Short-Term Investments			5
6	Prepaid Insurance	134,839		6
7	Other Prepaid Expenses	281,248		7
8	Accounts Receivable (owners or related parties)	257,083		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,142,708	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,232,107		12
13	Land	7,869,734		13
14	Buildings, at Historical Cost	70,095,577		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,805,416		16
17	Accumulated Depreciation (book methods)	(36,531,116)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	37,932		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	4,542,473		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 66,052,123	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 85,194,831	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,102,058	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	579,646		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,523,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	173,680		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	18,305		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37		1,118,274		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,515,276	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		45,294,963		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,294,963	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 51,810,239	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 33,384,592	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 85,194,831	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 36,939,737	1
2	Restatements (describe):		2
3	Adjustment to Reconcile Consolidated Opening Equity	(3,540,035)	3
4	and Consolidated Net Income to Nursing Facility		4
5	Amounts		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 33,399,702	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(15,110)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PRIOR YR ADJ - DEPREC		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (15,110)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 33,384,592	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,042,311	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,042,311	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	433,266	5
6	Therapy	502,142	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 935,408	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	674,734	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 674,734	23
D. Non-Operating Revenue			
24	Contributions	52,237	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,237	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation</u>	106,529	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 106,529	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,811,219	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,403,542	31
32	Health Care	2,274,221	32
33	General Administration	2,127,914	33
B. Capital Expense			
34	Ownership	310,626	34
C. Ancillary Expense			
35	Special Cost Centers	675,526	35
36	Provider Participation Fee	34,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,826,329	40
41	Income before Income Taxes (line 30 minus line 40)**	(15,110)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (15,110)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	2,148	\$ 51,126	\$ 23.80	1
2	Assistant Director of Nursing	1,157	1,205	23,081	19.15	2
3	Registered Nurses	9,319	9,705	202,465	20.86	3
4	Licensed Practical Nurses	22,633	24,054	414,525	17.23	4
5	Nurse Aides & Orderlies	66,937	70,834	767,898	10.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,850	5,104	53,014	10.39	8
9	Activity Director	3,719	4,160	56,088	13.48	9
10	Activity Assistants	14,420	15,425	126,673	8.21	10
11	Social Service Workers	7,594	8,481	90,470	10.67	11
12	Dietician					12
13	Food Service Supervisor	5,310	5,890	75,977	12.90	13
14	Head Cook	7,378	8,013	79,654	9.94	14
15	Cook Helpers/Assistants	25,719	27,233	199,296	7.32	15
16	Dishwashers					16
17	Maintenance Workers	7,274	8,130	105,462	12.97	17
18	Housekeepers	15,952	17,071	130,204	7.63	18
19	Laundry	6,191	6,765	54,770	8.10	19
20	Administrator	1,864	2,145	71,372	33.27	20
21	Assistant Administrator					21
22	Other Administrative	5,235	5,589	85,116	15.23	22
23	Office Manager					23
24	Clerical	6,032	6,542	58,223	8.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,937	4,266	77,489	18.16	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,955	2,123	20,413	9.62	32
33	Other(specify)	1,887	2,091	38,570	18.45	33
34	TOTAL (lines 1 - 33)	221,347	236,974	\$ 2,781,886 *	\$ 11.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	70	\$ 5,047	1, 3	35
36	Medical Director		11,447	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	25	906	10, 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	690	11, 3	44
45	Social Service Consultant	10	542	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	119	\$ 18,632		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,625	\$ 245,908	10, 3	50
51	Licensed Practical Nurses	958	31,335	10, 3	51
52	Nurse Aides	2,802	62,251	10, 3	52
53	TOTAL (lines 50 - 52)	9,385	\$ 339,494		53

Facility Name & ID Number PROVENA COR MARIAE CENTER

0041046

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership %	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function			Description			Description		
Teresa Wester-Peters	Admin.	0	\$ 71,372	Workers' Compensation Insurance	\$ 621		IDPH License Fee	\$	
Other	Other Admin.	0	181,910	Unemployment Compensation Insurance	0		Advertising: Employee Recruitment		
				FICA Taxes	103,715		Health Care Worker Background Check		
				Employee Health Insurance	124,628		(Indicate # of checks performed <u>60</u>)		
				Employee Meals	0		Dues & Subscriptions	72,345	
				Illinois Municipal Retirement Fund (IMRF)*	0		Advertising & Public Relations		
				Other Benefits	337,757				
					0				
					0				
TOTAL (agree to Schedule V, line 17, col. 1)				Home Office Allocation	48,877		Home Office Allocation	4,248	
(List each licensed administrator separately.)			\$ 253,282				Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	(63,649)	
Description			Amount				Yellow page advertising		
Miscellaneous			\$ 18,149						
Corp Service Fee			131,974						
Mgmt Fee			296,742						
Mgmt Fee Interest			258,636						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 705,501	TOTAL (agree to Schedule V, line 22, col.8)		\$ 615,598	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,944
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount	N/A			Out-of-State Travel	\$	
Legal Fees	Various		\$ 5,392						
Purchased Service	Various		6,934						
Purchased Service	Various		105				In-State Travel	2,796	
Accounting	Various		6,982						
Professional Services	Various		94						
Consulting	Various		1,170				Seminar Expense	0	
Consulting	Various		4,136				Business Meals		
Consulting	Various								
Consulting	Various		6,618				Home Office Allocation	5,310	
Consulting	Various		24,334				Entertainment Expense		
Consulting	Various		52,404				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 8,106	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 108,169						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **PROVENA COR MARIAE CENTER**

STATE OF ILLINOIS

0041046

Report Period Beginning:

1/1/2002

Ending:

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12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 5048 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 152
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,956 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,500
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. not issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.